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In The

Supreme Court of the United States

October Term, 1996

STEVEN B. LARSEN, IN HIS CAPACITY AS INSURANCE COMMISSIONER OF THE STATE OF MARYLAND,

Petitioner,

v.

AMERICAN MEDICAL SECURITY, INC., *et al.*,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

AMICUS CURIAE BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

Page

INTEREST OF THE NAIC 1

SUMMARY OF ARGUMENT 6

ARGUMENT 8

INTRODUCTION 8

I. THE COURT OF APPEALS' CONSTRUCTION OF 29 U.S.C. § 1144(A) IS INCONSISTENT WITH THE PRESUMPTION AGAINST PRE-EMPTION OF TRADITIONAL STATE POLICE POWERS 9

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S ERISA DECISIONS 12

III. THE DECISION BELOW CONFLICTS WITH DECISIONS OF OTHER COURTS OF APPEALS 14

IV. LAWS REGULATING THE BUSINESS OF INSURANCE ARE SAVED FROM PRE-EMPTION 15

CONCLUSION 18

TABLE OF AUTHORITIES

Page

CASES:

Alessi v. Raybestos Manhatton, Inc., 451 U.S. 504 (1981) 10

California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., 117 S. Ct. 832 (1997) 10

DeBuono v. NYSA-ILA Medical and Clinical Services Fund, 117 S. Ct. 1747 (1997) 6

District of Columbia v. Greater Washington Board of Trade, 506 U.S. 125 (1992) 10

FMC Corp. v. Holliday, 498 U.S. 52 (1990) .. 7, 12, 13, 17

Gonzales v. Prudential Ins. Co. of America, 901 F.2d 446 (5th Cir. 1990) 7, 14, 15

Hillsborough County v. Automated Medical Laboratories, Inc., 471 U.S. 707 (1985) 6

Jones v. Rath Packing Co., 430 U.S. 519 (1977) 6

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) ..... *passim*

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) ..... *passim*

Securities and Exchange Commission v. National Securities, Inc., 393 U.S. 453 (1969) 7, 14

U.S. Dept. of the Treasury v. Fabe, 508 U.S. 491 (1993) 14

TABLE OF AUTHORITIES – Continued

Page

STATUTES:

15 U.S.C. § 1011 2

29 U.S.C. § 1001 3

§ 1002(1) 7, 16, 17, 18

§ 1144(a) 6, 9

§ 1144(b)(2)(A) 9, 17

§ 1144(b)(2)(B) 7, 9, 14, 17

OTHER AUTHORITIES:

Couch on Insurance 3d 1:4 12

NAIC Model Laws, Regulations and Guidelines VOL. I, p. 92, "NAIC Stop-Loss Model Act" (October 1995) 2

INTEREST OF THE NAIC

The National Association of Insurance Commissioners (NAIC) is a non-profit, unincorporated association established in 1871, whose membership consists of the principal insurance regulatory officials of the 50 States, the District of Columbia, the territories and insular possessions of the United States.

In submitting this *amicus curiae* brief, the NAIC seeks to demonstrate its interest in this proceeding and to fulfill the mission of the NAIC, as set out in its Constitution, to:

> . . . assist state insurance regulators, individually and collectively, in serving the public interest in achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost-effective manner, consistent with the wishes of its members:
>
> 1. Protect the public interest, promote competitive markets and facilitate the fair and equitable treatment of insurance consumers;
> 2. Promote the reliability, solvency, and financial solidity of insurance institutions; and
> 3. Support and improve State regulation of insurance.

The interest of the NAIC arises out of the regulatory responsibility vested in each insurance regulator [hereinafter commissioner] to see that all laws respecting

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**Amicus* states pursuant to Rule 37.6 that no counsel for a party authored this brief in whole or in part and no person or entity, other than the *amicus curiae*, its members, or its counsel, made a monetary contribution to the preparation or submission of this brief.

insurance companies and the types of policies offered for sale in his or her State are executed faithfully. The commissioners of the various States are charged with the responsibility of regulating the business of insurance within their jurisdictions pursuant to the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, and State insurance laws.

One of the most important activities conducted by the members of the NAIC is the development and drafting of model statutes and regulations to address common problems nationwide. These models are intended to serve only as guideposts for members when presenting proposed insurance legislation in various State legislatures and in adopting appropriate regulations for more efficient and effective regulation of insurance in the States.

For the same underlying marketplace abuses identified by the Petitioner (Pet. Brief 8-10), the members of the NAIC drafted a model substantially similar to the Maryland regulation that is the subject of this case. *See, NAIC Model Laws, Regulations and Guidelines,* VOL. I, p. 92, "NAIC Stop-Loss Model Act" (October 1995).

The NAIC Stop-Loss Model Act establishes criteria to determine whether a policy submitted to a commissioner for approval prior to sale and denominated as a stop-loss insurance policy by the insurer is, in reality, performing in substantially the same way as a health insurance policy and thus should be subject to State laws regulating health insurance. The purpose of the NAIC model is to establish a fair and reasonable actuarial standard for the determination of whether the risk transfer agreement (the policy) should be treated as a health insurance policy or

as a stop-loss insurance policy for purposes of State regulation of insurance. Generally, the actuarial standards in the NAIC model require that insurers that sell stop-loss insurance cannot assume more than 50% of the risk of loss for the covered medical expenses of employees. If insurers assume more than 50% of the risk, insurers must re-file the policy form under the State's laws regulating health insurance policies. The Maryland regulation in this case parallels the NAIC model but permits insurers to assume an even higher proportion of the employer's risk of loss for medical expense claims and still have the policy form approved as a stop-loss insurance product.

Neither the Maryland regulation nor the NAIC model imposes any obligations on employee welfare benefit plans established under the Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1001, *et seq*. Commissioners have a special responsibility to assist their States in controlling health care costs and in expanding access to health insurance. Since the Federal government appears to have abandoned its efforts to craft a comprehensive health-care plan, it is imperative that States, through their commissioners, remain free to correct abuses in the health care marketplace. The regulation in question establishes a "bright-line" definition that draws a rational distinction between two types of insurance policies. The line is actuarially based on the amount of risk the policy shifts to the insurer so as to distinguish true stop-loss insurance, which covers only catastrophic losses, from policies that are captioned as stop-loss, but that transfer substantial responsibility to the insurer for funding the covered medical expenses of an employee welfare benefit plan.

Preserving the traditional authority of the States to draw the legal distinctions between different types of insurance policies does not hinder the overall goals of ERISA, but rather supports them. The United States Congress enacted ERISA to provide effective protection for plan participants, and recognized that the States had the expertise needed to regulate the insurance policies that employee welfare benefit plans purchase. Accordingly, ERISA's "savings clause" expressly excludes state laws regulating insurance from pre-emption, even when those laws relate to employee welfare benefit plans. The McCarran-Ferguson Act delegates to the States the exclusive authority to regulate the business of insurance. States are free to permit or not to permit the types of insurance products offered for sale within their jurisdiction.

The court of appeals' decision below gives a new and unintended meaning to this Court's *dicta* in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985) which stated: "We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." That distinction flowed directly from the States' reserved authority to regulate insurance, and was not intended as a limitation on that authority.

The court of appeals used this language to draw an impermissible distinction between employee benefit plans that purchase one type of insurance policy to cover their loss exposure and those that purchase a different type of insurance policy. ERISA contains no authority for

that distinction. The distinction this Court drew in *Metropolitan Life* was not between the types of insurance policies purchased by plans, but "between insured and uninsured plans." The term "insured plan" has a simple and straightforward meaning in this context: a plan that purchases an insurance policy. To the extent that a plan choosing to buy a particular insurance policy is affected by state regulation of that policy, it is a permissible "indirect regulation" of that insured plan within the meaning of *Metropolitan Life*. This Court expressly stated in *Metropolitan Life* at 746-47:

> We therefore decline to impose any limitation on the "savings clause" beyond those Congress imposed in the clause itself and in the "deemer clause" which modifies it. *If a State law "regulates insurance," as mandated-benefit [in this case, stop-loss] laws do, it is not preempted.* Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause, *whether it be the . . . attempt to save only state regulations unrelated to the substantive provisions of ERISA*, or the insurers' more speculative attempt to read the "savings clause" out of the statute (emphasis added).

The NAIC encourages the Court to reverse the decision of the Fourth Circuit so that the substantive terms, benefits and types of insurance policies offered for sale in the marketplace will remain fully within the regulatory scope of authority of the individual States. This is consistent with statutory law and common law and is in the

best interest of insurance consumers, whom commissioners are charged by both State and Federal law to protect.[1]

SUMMARY OF ARGUMENT

1. Section 1144(a) of ERISA expressly preempts State laws that "relate to any employee welfare benefit plan." 29 U.S.C. § 1144(a). However, the court of appeals' decision extends the preemptive effect of 29 U.S.C. § 1144(a) far beyond the bounds intended by Congress. The court of appeals failed to construe the express preemptive language of 29 U.S.C. § 1144(a) in light of the presumption against pre-emption. This Court has always analyzed ERISA pre-emption cases on the assumption that the historic police powers of the States were not to be superseded unless that was the clear and manifest purpose of Congress. *See, Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977). The Court has also noted that the historic police powers of the State include the regulation of matters of health and safety. *See, DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 117 S. Ct. 1747, 1752 (1997) (quoting *Hillsborough County v. Automated Medical Laboratories, Inc.*, 471 U.S. 707, 715 (1985)). When read in connection with this Court's earlier cases, the court of appeals failed to give proper weight to this Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). The court of appeals failed to use the proper standard when it determined that

[1] The parties have consented to the filing of this *amicus curiae* brief. Stipulations indicating their consent have been filed with the Clerk of the Court.

the Maryland regulation "relates to" an employee welfare benefit plan.

2. The court of appeals erroneously concluded that the Maryland regulation "deemed" ERISA plans to be an insurance company within the meaning of ERISA's "deemer clause." 29 U.S.C. § 1144(b)(2)(B).

The court of appeals also implied that the Maryland regulation did not regulate the business of insurance, in direct conflict with previous decision of this Court. *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 460 (1969).

3. The court of appeals' extravagant reading of the "deemer clause," 29 U.S.C. § 1144(b)(2)(B), conflicts with the better-reasoned Fifth Circuit case of *Gonzales v. Prudential Ins. Co. of America*, 901 F.2d 446, 453-54 (5th Cir. 1990).

4. The NAIC requests this Court to accept *certiorari* and hold that all State laws regulating the business of insurance that only indirectly affect an employee welfare benefit plan are "saved" from pre-emption. This would create a safe-harbor rule from ERISA pre-emption for all State laws regulating the business of insurance.

The NAIC requests this Court to adopt the interpretation of the "deemer clause," 29 U.S.C. § 1144(b)(2)(B), that was urged by Justice Stevens in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). ERISA plans provide benefits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). ERISA does not preempt a State's right to regulate the relationship between an

insurer and insured or control the design of insurance policies.

ARGUMENT

INTRODUCTION

The NAIC is vitally concerned that insurers not be allowed to charge into the regulatory gap created by the court of appeals' decision. Pet. App. 14a. The decision below permits insurers to circumvent the State of Maryland's right under Federal law to regulate and control the relationship between an insurer and an insured and the type of policies permitted to be sold in its marketplace. Maryland has enacted needed health-care reforms, including certain health insurance statutes, in the best interests of its citizens. The court of appeals' decision permits insurers to subvert and avoid Maryland's health insurance laws and engage in a scheme of deception that exploits form over substance. If left to stand, the decision allows health insurers to merely caption a policy as stop-loss insurance and escape any further regulation by the State.

The commissioner's promulgation of the regulation was simply an attempt to provide a "bright-line" definition between permitted types of stop-loss policies and health insurance policies sold in Maryland. The reason to establish a bright-line is to give guidance to insurers when designing policies for submission and approval by the commissioner, as required by Maryland law.

I. THE COURT OF APPEALS' CONSTRUCTION OF 29 U.S.C. § 1144(a) IS INCONSISTENT WITH THE PRESUMPTION AGAINST PRE-EMPTION OF TRADITIONAL STATE POLICE POWERS.

Three provisions of ERISA speak to the question of pre-emption. These include: 1) the "pre-emption clause," which states that the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter 'relate to' any employee [welfare] benefit plan," except as provided in the "savings clause" 29 U.S.C. § 1144(a); 2) the "savings clause," which states that "except as provided in the deemer clause, nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities" 29 U.S.C. § 1144(b)(2)(A); and, 3) the "deemer clause," which states that:

> Neither an employee benefit plan . . . nor any trust established under such a plan shall be deemed to be an insurance company, or other insurer . . . or to be engaged in the business of insurance . . . for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts . . .

29 U.S.C. § 1144(b)(2)(B).

In 1995, this Court sent a message for heightened judicial restraint when determining whether State laws were pre-empted by ERISA. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), the Court, in a unanimous decision, clarified the outer reaches of the first prong of the ERISA pre-emption test, whether a State law impermissibly "relates to" an employee welfare benefit plan within the meaning

of the ERISA pre-emption clause. The court of appeals below made no reference to *Travelers* and chose instead to rely on *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125 (1992); and *Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504 (1981).[2] However, these cases can be distinguished because the State law in question, whether found after analysis to "relate to" or not, would have applied directly to all employee welfare benefit plans. In the matter before this Court, Maryland's regulation applies only to insurers, and would only indirectly affect employee welfare benefit plans that voluntarily choose to purchase a certain type of insurance in the State. The court of appeals erroneously concluded that since the regulation referenced ERISA plans, it "relates to" ERISA plans. Pet. App. 10a. Maryland's regulation only made reference to employee welfare benefit plans for the purpose of explaining why aberrant insurer conduct in the marketplace needed adjustment by clarifying regulation. The court of appeals correctly found that the "regulations [in this case] are carefully drafted to focus directly on insurance companies issuing stop-loss insurance and not on the employee benefit plans themselves." Pet. App. 11a. However, having so held, the court of appeals then failed to apply this Court's standard that "laws that regulate only the insurer, or the way in which it may sell insurance, *do not relate to benefit plans.*" *Travelers* at 663 (emphasis added).

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[2] The court of appeals also cited to *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*, 117 S. Ct. 832 (1997). However, the court of appeals failed to analyze this case consistent with this Court's methodology in *Dillingham*, which was first articulated in *Travelers*.

The court of appeals should have started by analyzing the "relates to" question using the analysis used by this Court in *Travelers*. A "relates to" analysis should be done regardless of whether the State law in question appears at first reading to regulate insurance. "The basic thrust of the pre-emption clause, then, was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers* at 657. The Maryland regulation leaves employee welfare benefit plans free to establish their own benefit structures and administration. However, after investigating the types of insurance policies in the marketplace, some plans may decide it is more favorable for them to purchase a policy to provide benefits to their participants as opposed to designing their own unique benefit structure and self-funding the risk associated with it. The regulation affects plans that voluntarily choose to purchase a policy, thus it only indirectly influences some plans. The regulation does not bind all plan administrators to any particular choice of benefit structures or administration. The influence only affects a plan's "shopping decisions." *Travelers* at 660. Maryland's regulations "leave plan administrators right where they would be in any case, with the responsibility to choose the best overall coverage for the money." *Travelers* at 662.

Applying the analysis of *Travelers*, the NAIC urges the Court to find that the regulation does not "relate to" employee welfare benefit plans.

II. THE DECISION BELOW CONFLICTS WITH THIS COURT'S ERISA DECISIONS.

The NAIC adopts the Petitioner's arguments that the court of appeals' decision below conflicts with the Court's ERISA decisions. The court of appeals erred by holding that the Maryland regulation "violates the ERISA provision that no ERISA plan 'shall be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate contracts.' " Pet. App. 12a. As briefed by Petitioner, the holding conflicts with this Court's earlier decisions. The court of appeals erred by drawing a distinction between self-funded plans and insured plans that is contrary to the one this Court drew in *Metropolitan Life* and in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990). In *FMC* at 54, the Court distinguished between these types of plans by explaining that a "self-funded" plan is one that does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants.[3] The court of appeals misreads this to craft an impermissible distinction between policies sold to employers (or employee welfare benefit plans) in

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[3] A leading treatise on insurance law defines a "self-insurer" as follows: "Strictly speaking, this is an entity which, rather than purchasing insurance, undertakes to guard against its own risks by assessing the risks and establishing sufficient reserves to pay any losses which occurs. In practice, the term self-insured tends to be applied to any party who does not possess insurance, regardless of whether formal risk assessment has occurred or reserves were established. In the latter usage, there is no difference between a party who is uninsured, and one who is self-insured, while in the former usage, a self-insurer is very different from one who is uninsured." *Couch on Insurance 3d 1:4.*

the form of stop-loss insurance and policies sold to employers where plan participants have an express contractual right to benefits. The court of appeals then labels the former a "self-funded" plan and the latter an insured plan. Pet. App. 7a. ERISA contains no such distinction. An ERISA plan that chooses to purchase any type of insurance policy to satisfy its obligations is an insured plan, and State law may indirectly regulate such an ERISA plan through regulation of its insurer and its insurer's insurance contracts. *FMC* at 64.

The court of appeals' decision also implied that the Maryland regulation failed the third test set forth in *Metropolitan Life* for analyzing whether a law regulates the business of insurance – is the law's reach limited to entities within the insurance industry? – because they "interfere with the relationship between ERISA plans and their participants." Pet. App. 11a. The court of appeals' analysis misses the central point of *Metropolitan Life*, which is that a law that directly regulates only the insurer-insured relationship does *not* cease to be a "law regulating insurance" merely because it is also intended to have an indirect effect on other relationships. The regulation does not "interfere" with the plan-participant relationship in any manner other than the manner this Court expressly endorsed in *Metropolitan Life*. This Court has repeatedly held that the:

> relationship between an insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement – these were at the core of the "business of insurance. . . . " Statutes aimed at protecting or

> regulating this relationship, directly or indirectly, are the laws regulating the "business of insurance."

Securities and Exchange Commission v. National Securities, Inc., 393 U.S. 453, 460 (1969). *See*, also, *U.S. Dept. of the Treasury v. Fabe*, 508 U.S. 491, 501 (1993) (statutes aimed at regulating the relationship between an insurer and its insured, directly or indirectly, are laws regulating the business of insurance).

ERISA expressly saves all laws regulating the business of insurance, whether the type of policy permitted for sale in the marketplace is issued to an employer, an employee welfare benefit plan, or to plan participants.

III. THE DECISION BELOW CONFLICTS WITH DECISIONS OF OTHER COURTS OF APPEALS.

The NAIC adopts Petitioner's arguments that the court of appeals' extravagant reading of the "deemer clause," 29 U.S.C. § 1144(b)(2)(B), conflicts with decisions of other courts of appeals. In *Gonzales v. Prudential Ins. Co. of America*, 901 F.2d 446, 453-454 (5th Cir. 1990) ("deemer clause" prevented application of disability insurance law directly related to an ERISA plan), the court concluded that:

> Nothing in the "deemer clause" prohibits the application of State insurance laws to an insurer of an ERISA plan or to an insurance policy issued by such an insurer. Thus, by regulating the insurer or the insurer's policy, the State may without running afoul of the "deemer clause", "indirectly" influence the content and operation of an insured ERISA plan. However, the State

> may not accomplish this end directly; that is, it may not apply and enforce its insurance laws in such a way that an ERISA plan, as opposed to the insurer of the plan must conform to them or will face liability for failure to conform to them (footnote omitted).

The decision in *Gonzales* cannot be reconciled with the decision of the court of appeals below. The Fifth Circuit clearly articulated that States may regulate an insurer's policies sold to ERISA plans without running afoul of the "deemer clause" even though the regulation indirectly affects an ERISA plan. The court of appeals' decision conflicts with *Gonzales* by holding that even though Maryland's "regulations are carefully drafted to focus directly on insurance companies issuing stop-loss insurance, and not on the employee benefit plans themselves," Pet. App. 11a, those laws violate the "ERISA provision that no ERISA plan 'shall be deemed to be an insurance company. . . . ' " Pet. App. 12a. The court of appeals' decision conflicts with the Fifth Circuit, which correctly applied this Court's decision in *Metropolitan Life*.

IV. LAWS REGULATING THE BUSINESS OF INSURANCE ARE SAVED FROM PRE-EMPTION.

The NAIC urges the Court to expand its discussion in *Travelers* regarding *Metropolitan Life*. In *Travelers*, the Court opines on one hand that mandated coverage laws bear indirectly and substantially on all insured benefit plans, but on the other that laws regulating only the insurer, or the way in which it may sell insurance, do not relate to benefit plans. The Court went on to recognize

that not all regulations influencing cost would "relate to" employee welfare benefit plans within the meaning of ERISA pre-emption. *Travelers* at 663.

This means that before applying the "savings clause," courts should always apply a "relates to" analysis to State laws, even if they appear, on their face, to be laws regulating the business of insurance. Not all laws regulating the business of insurance will "relate to" employee welfare benefit plan structures or their administration. *Travelers* at 663-64. If the "relates to" analysis concludes that it is such a law, then the court must next determine whether it is a law that regulates the business of insurance. As this Court found in *Metropolitan Life*, if the insurance law bears indirectly, but substantially, on an employee welfare benefit plan because the plan purchased a policy of insurance to directly pay for or to reimburse for benefits to "employees in the event of sickness, accident, disability, death or unemployment," 29 U.S.C. § 1002(1), then the law is "saved" from pre-emption. In effect, the Court holds that all State laws regulating the business of insurance, by definition, affect employee welfare benefit plans only indirectly, and are therefore, "saved" from pre-emption. In this context, "indirectly" means that the:

> . . . focus [of the statutory term] was – it was on the relationship between the insurance company and the policyholder. Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."

S.E.C. at 460.

Under the ERISA statute, employers may establish and maintain an "employee welfare benefit plan." These

plans offer a variety of medical, surgical, hospital and other benefits to employees in the event of sickness, accident, disability, death or unemployment. Employers may provide these benefits *through the purchase of insurance or otherwise.* 29 U.S.C. § 1002(1). ERISA makes no distinction between the types of insurance an employer (or employee welfare benefit plan) may purchase, clearly leaving the States in control of what policies may be offered for sale in the marketplace by insurers. An expansion of the discussion in *Travelers* would provide a common-sense meaning to ERISA's "savings clause." 29 U.S.C. § 1144(b)(2)(A). Congress intended to create a safe harbor from ERISA pre-emption for all State laws regulating the business of insurance, whether those laws substantially affect "insured" ERISA plans or not.

This approach would also provide a basis for a coherent interpretation of the "deemer clause," 29 U.S.C. § 1144(b)(2)(B). The "deemer clause" should act as the bright-line between ERISA plans and State laws that are unquestionably directly aimed at employee welfare benefit plans, as urged by Justice Stevens. *FMC* at 68-69. The "deemer clause" was necessary in order to prevent States from abusing their reserved authority to regulate insurance by forcing self-funded employee welfare benefit plans to seek authority as licensed insurance companies. Employee welfare benefit plan activities operate just like those of an accident and health insurance company: benefit schedules are designed, conditions of coverage are written, actuarial calculations of anticipated costs are estimated, administrative procedures are set up to pay claims, premium schedules are established (increasingly with higher percentages coming directly from employees)

and agents are hired to explain the differences in plan benefits to participants. Collecting premiums from people (employees) in exchange for promising them reimbursement for contingent amounts of medical expenses under a defined benefit schedule is the business of insurance. Without licensure as an insurer, these activities would be illegal under State unauthorized insurance laws, and therefore the "deemer clause" was enacted to give meaning to the Congressional intent to exempt these plans from direct State regulation.

However, ERISA plans may provide benefits "through the purchase of insurance or otherwise," 29 U.S.C. § 1002(1), and the "deemer clause" was never intended to apply to the insurance policies that the plans might purchase. When plans decide it is a better deal to purchase insurance, as opposed to self-funding their obligations, they should be required to do so just like any other purchaser in the marketplace. As this Court made clear in *Metropolitan Life*, ERISA does not preempt a State's right to regulate the relationship between an insurer and insured or control the design of policies.

CONCLUSION

The implications raised by the issues in this case are far-reaching. The pre-emption of State laws permitted by the decision of the court of appeals will be felt around the nation. It is typical that when a stop-loss policy is sold to an employee welfare benefit plan, the only State to have reviewed the design of the policy is the State that

approved the policy form, regardless of where plan participants covered by the policy may reside. Employees covered under such a policy may be living in any of the NAIC member States. As more and more employers come to the Fourth Circuit to take advantage of the pre-emption created by the court of appeals, the effect on employees living elsewhere will grow. Employees today, who perhaps have health insurance policies conforming to North Dakota law, may soon find their policies redesigned by an employer who locates its ERISA plan in Maryland in order to purchase an unregulated stop-loss policy. The court of appeals erroneously states that Congress has created this regulatory gap and that only Congress can close it. Pet. App. 14a. The NAIC respectfully requests that the Court grant the Petitioner's *Petition for a Writ of Certiorari*. A decision on the merits would fill the regulatory gap created by the court of appeals and reaffirm that regulation of the business of insurance is reserved exclusively to the States.

Respectfully submitted,

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